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# **Safeguarding Adults Reviews: Prompting Practice and Policy**

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As a whole there was remarkably little controversy in England over the Care Act 2014, once debates over funding caps had been kicked into the long grass. After all, who could oppose the idea of better information, clearer entitlements, and more support for carers? Among the non-contentious areas were specific proposals for Serious Case Reviews (SCRs) to become Safeguarding Adults Reviews (SARs). In light of the many concerns in children's services about the dominance of SCRs in policy and practice debates this lack of interest and discussion may seem surprising. In this paper we explore why such reviews concerning adults are largely seen as non-contentious and frame our analysis around four different 'prompts'; those from Parliament, from earlier SCRs, from practice analysis and from practice development. We draw on our own wider research programme on Adult SCRs and subsequently SARs. This programme of research has explored different facets of the review process and undertaken different thematic analyses by location or user group.

## **The Parliamentary 'Prompt'**

In parliamentary proceedings the Care and Support Bill (the pre-legislative form of the later Care Act 2014) proposed that one responsibility of local Safeguarding Adults Boards (SABs) would be to review cases where abuse or neglect were suspected, or where a person had died or there was reasonable concern over how

an agency had acted (including injury or a 'near miss'). Clause 36(2) placed a duty on SAB members to co-operate and contribute to any review (see SCIE 2015 for further details of the new approach). Social workers, among others, would therefore be potentially in a position to propose that a SCR would be warranted or not, would have to take part in a review, and could be responsible for implementing its' recommendations. The Care Act 2014 largely conferred responsibilities for decisions about a SAR to local SABs. While many professionals will be engaged in these reviews there will likely be much social work input. Some of this input will be an account of practice in the particular case but there will also be room for social workers to contribute to system- wide discussions during the review and in the implementation of recommendations arising from it.

By way of example of local interpretation of the new powers and duties, Suffolk County Council offered the following as the context of a recent SAR in the case of a Mr AA (Klee 2015):

*Under the provisions of the Care Act 2014 all Safeguarding Adults Boards (SABs) are required to undertake a Safeguarding Adults Review (SAR) overseen by an Independent Report Writer in order to learn lessons and improve practice when a situation arises with a person in their area who requires care and support, where doubts are raised about the quality of service they received and deserved. The key aim of the SAR is not to investigate or apportion blame, but to examine professional practice and*

*adjust this practice in light of lessons learnt. These lessons are vital to reduce the risk of occurrence. (Suffolk County Council 2016)*

### **Prompts from the history of Adult SCR's**

The public visibility of the SCR into Winterbourne View Private Hospital (Flynn 2012) shows the power and influence of a SCR, but this SCR was an exception (Manthorpe and Martineau 2011) since it was a Ministerial-initiated high profile inquiry. Almost all SCR's have been more local in focus and many have not had an independent Chair. Most did not command major resources (Manthorpe and Martineau 2012). Indeed the optional or discretionary nature of SCR's meant that there also existed a sub-stratum of reports that social workers and others had compiled prior to, or instead of, SCR's. Such documents were and are still used as an alternative to a SCR, being termed an internal review, or other type of inquiry.

Nonetheless, the Winterbourne View SCR is a powerful read and a research document in its own right and occupies an important place in the history of inquiries and SCR's. It may have prompted goodwill about adult SCR's as it showed the value of a forensic examination of a system that could touch the lives of many people.

Flynn found that South Gloucestershire Council Adult Safeguarding Service had received 40 safeguarding alerts about patients at Winterbourne View Hospital. These concerned patients who had been 'imported' from other localities. The local authority safeguarding service's expectation that the Hospital staff would honestly report the circumstances concerning all allegations of abuses and crimes was misplaced, concluded Flynn, who perceived safeguarding staff as deferring to Police conclusions. She added:

*‘Safeguarding work has to cross professional and organisational boundaries and the task of developing and maintaining relationships is paramount. South Gloucestershire Council Adult Safeguarding acknowledges that they should have challenged some of the assumptions of the police, for example by pressing for fuller explanations of decisions. As their concern about such decisions increased, these should have been referred to the Safeguarding Adults Board for multi-agency consideration’ (4.16).*

This SCR had clear policy implications and has prompted reviews and policy about the care and treatment of people with learning disabilities – for example, about the need to monitor ‘out of area’ placements, to reduce these where possible, and about the quality of hospital assessment overall (see Local Government Association 2015). For social work practice there were further multi-faceted messages that seemed to chime with the profession’s values. One of these was the importance of talking directly to people potentially affected by the abuse and to their families. Flynn found from her discussions with the families of patients who were abused at Winterbourne View that they: *‘... no longer regard professionals as the bearers of legitimate knowledge’* (Section 4, 1.2). This sentiment may be widely shared by other carers and family members whose relatives have been abused or neglected – not just among learning disability user and carer groups. Social work has generally welcomed the opportunity to reform the systems implicated in the Winterbourne View SCR (The College of Social Work 2013).

Margaret Flynn also conducted an earlier SCR into the death of Steven Hoskin (Flynn 2007) which has its own place in the history of SCRs, leaving a powerful

legacy in the form of a challenge to practice. This type of SCR is more typical of such reviews in that it focused on one individual – here a person with substantial history of being let down by services and those he trusted. It revealed the multiplicity of systems surrounding a vulnerable child and later adult. As she summarised (Flynn 2013), across his life Steven was “victimised” – when he was in an Assessment and Treatment Unit; as his family home life became characterised by conflict after the death of his grandfather who shared the family home; and as he began to drink alcohol, ultimately excessively. While the details of his application for housing observed, “*he is very vulnerable and can be taken advantage of due to the way he looks i.e. his learning disability*” (cited in Flynn 2013, slide 7), after he acquired accommodation he also acquired a lodger – in a one room ‘bed-sit’ flat. Moreover, young boys took to hanging around, coming into his bed-sit, and misusing substances there. Among the wide range of professionals and agencies that came across Steven, Flynn found a tendency to ‘deify’ a person’s ‘choice’ rather than to question whether someone might be exerting pressure on him. She concluded that task-driven health and social care practice may result in the closure of cases without proper consideration of the risks to the individual – these risks becoming heightened when the adult appeared to be exercising choice and not to have high levels of need for care. This review raised questions about the proper balance of autonomy and risk of harm, and identified ‘mate abuse’ as part of the complexities of exploitation and grooming.

## **Prompts for practice**

This section discusses three potential implications for social work practice in the context of SARs as they are developing.

Sometimes known as Internal Management Reviews (IMRs), the 'detective work' of compiling these is familiar to many social workers in managerial roles who have to respond to complaints or concerns. Social work managers will continue to be required to compile IMRs and to respond to complaints, provide statements for Coroners, and undertake other scrutiny. SCRs, when renamed SARs, did not suddenly grow in number following the Care Act 2014, but referring to them as 'statutory' will likely have the effect of increasing numbers and significance.

Managers need confidence that what they are writing, its structure, and the level of detail are 'fit for purpose'. It appears that there are more SARs available on local authority websites than previously, providing examples of what such documentation should contain. For such professionals, the need to be clear about the SAR's terms of reference is vital. Those commissioning such reviews need to ensure that there are terms of reference for a SAR and that communications with professionals are clear and their position respected.

While there is a strong reaction against unnecessary paperwork, at the frontline social work records will remain important. Supervision and peer support around cases also need to be captured to convey the fine-grained decision making in social work and the consideration of risk – especially risks of harm and risk empowerment. Not all incidents will have clear evidence of harm and there may be complex interpretations about individuals' abilities to make their own choices.

At the level of the profession, what can stop a blame culture developing around SARs? How can social workers support colleagues and get support for themselves

when practice is questioned? There are fundamental questions about whether reviews and inquiries are good learning tools or whether they reinforce pessimism and risk aversion. From children's services there is worrying evidence of the ways in which inquiries and reviews have impacted negatively on professional morale among social workers. In a wide-ranging study of the impact of children's SCRs' processes and publication Rawlings et al (2014) concluded that the length, time and content of reviews created an '*ethos of 'blame,' avoidance, apathy, defensiveness and increased workload*' (page 6). These trends are fuelled by media reporting.

Managers and frontline workers confessed to being overwhelmed by the number of SCRs nationally and found it difficult to examine them in the local context. As a consequence, what attracted attention becomes interpreted with the benefit of hindsight, partially interpreted, may become skewed and may be affected by other interests of the media or politicians. Considering the potential to learn from children's SCRs Rawlings et al (2014) found that the reports were not accessible or manageable; key themes and learning were not adequately identified; and they were not only expensive but that value for money was not always evident. They cautioned that hopes to improve the SCR process using a 'systems approach' were not yet evidenced and that such a putative non-blaming approach would require considerable investment and sustained commitment from the relevant agency (page 40). The Wood report (Wood 2016) echoed these criticisms and the government has agreed that the Children's Serious Case Review system should be substantially changed. It is proposed that there be national SCRs commissioned and far fewer local reviews (Department for Education 2016).

Those contributing to SARs have much to learn from the coming evidence of these initiatives. To an extent some of this will be under the control of the safeguarding



community itself. It is charged with the powers to determine whether to have a SAR and to set out its terms of reference. Already there are middle management considerations of how to manage expectations and expense, illustrated by suggestions for a system whereby someone from one SAB undertakes a SAR in another nearby area or part of a region, and vice versa (Guerin 2015, p.4).

### **Prompts for practice development**

In social work there has been long-standing concern about people who lead chaotic lives, are hard to engage, are living in poor conditions, fail to care for themselves, and distress others through self-neglect and hoarding. All of these present dilemmas in practice – of action or inaction, rights or risks, client safety or neglect, urgency or watchful waiting. Among practitioners the term self-neglect is increasingly employed and this provides at least some common language. It now generally refers to a person's unwillingness or inability to care for themselves and/or their living environment. Nonetheless it still encompasses different behaviours, including hoarding, living in squalor or chaos, as well as neglect of oneself, sometimes related to mental health problems or impaired cognition. SCRs have provided authentic 'real world' examples of the difficulty of practice with people who may be self-neglecting.

The Care Act 2014 Statutory Guidance, as revised in 2016 (Department of Health 2016), recognised self-neglect as a possible category of abuse. This means that people who self-neglect may currently be supported by safeguarding adult approaches, including Making Safeguarding Personal, as well as receiving more general support from practitioners from different agencies and professions. According to the Guidance, self-neglect includes 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes

behaviour such as hoarding' (4.17). The revised Statutory Guidance suggests that this may not prompt a section 42 enquiry, but that an assessment should be made on a case-by-case basis to consider whether a response is required under safeguarding on the basis of the adult's ability to protect themselves by controlling their own behaviour. The challenges of doing this – and balancing the individual's autonomy with their safeguarding – are amply illustrated in several SCRs, the findings of which were considered as a group in analyses conducted by Braye and her colleagues (2015a; 2015b; 2011). They explored the findings from 40 SCRs where self-neglect was described as one of the characteristics of the adult involved or it featured in the context of the harm or risk of harm that led to the SCR. This work has helped practice development.

Like other analyses of adult SCRs, including our own on dementia related cases (Manthorpe and Martineau 2016), a set of relevant SCRs had to be compiled. This presented the first challenge since it was necessary to track down published and unpublished summaries or reports. Braye et al (2015a; 2015b) classified them by noting whether the individual concerned was male or female, their age, their living situation and the circumstances of their death. In some of these categories even this very basic information was not reported. Importantly they also established whether the self-neglect focus was central to the SCR report, or implicit, or even peripheral.

Such syntheses, based on a patchwork of material, may be easier following the Care Act's changes as the Guidance may promote greater uniformity of reports. It will be interesting indeed to see if the recommendations of SARs are any different. Braye et al (2015a) found that of the SCRs they examined, most (27) recommended training or staff support, while many (24) recommended the development, review and

dissemination of guidance or procedures, closely followed in number by recommendations that procedure was needed for referral and assessment of need and risk (23). Comparing the SCRs in a 'cross case analysis' they developed an index of key themes. These were applied to a fourfold domain matrix, which was portrayed as a series of concentric circles surrounding 1) the practitioner and the individual; 2) the professional team(s) round them both; 3) the organisations surrounding the professional team; and 4) the interagency governance surrounding the organisations, in terms of the workings of the local SAB.

Like other analyses of SCRs (see Manthorpe and Martineau 2014; 2016), Braye et al (2015a) tracked down as many published and unpublished summaries or reports as they could using various contacts and searches. The SCRs obtained ranged in size from 5 pages to 63 pages and covered the period 2003-13. Some were full reports, others only executive summaries, and 4 had not been published. The number of recommendations similarly varied, from 4-26, with some SCRs' recommendations containing various sub-elements while other SCRs included an Action Plan instead.

Those particularly salient to self-neglect policy and practice relate to the new policy acceptance that self-neglect may be the proper concern of safeguarding. This may prompt more wholesale skills development and practice learning. It may require more detailed examination of apparent refusals of services and rejection of information and advice. It may mean reworking of understandings of presumption of capacity and acceptance of unwise decisions. Braye et al (2015b) highlight that SCRs are not the vehicle to explore underlying feelings, values and beliefs that seem to be so important in practice with people who are at risk of self-neglect or are already self-neglecting. While practitioners have their own feelings and experiences

there is also the suggestion that organisational culture plays a part in responses to self-neglect, including the commitment of resources.

However, one important observation made by Braye et al (2015a) is that of conflicting or confounding evidence. There is evidence from many of the SCRs that professionals do not always follow procedures – yet the SCRs often call for further proceduralism – more policy and procedures, more guidance. Similarly, SCRs may give the impression that professionals should act rationally whereas the nature of their work means that they have many constraints on their choices and are influenced by personal, team and agency cultures. Braye et al (2015b) suggested that some SCRs have underplayed the importance of the interconnections between the four domains that they identified as relevant to safeguarding practice.

However, good practice is evident in many of the SCRs, such as following procedures correctly, good joint working on risk and decision making, information sharing and raising concerns. It seems that synchronicity is the key to making sure good practice is not solely reliant on individual professionals but is part of systems. In such a way supervision and communication between practitioners are mirrored by good multi-agency engagement.

Thus while self-neglect is newly articulated as inherently part of safeguarding practice and systems, SCRs have for many years been a way of establishing where things went wrong in this area of concern. Interestingly, Braye and her colleagues (2015a) concluded that SCRs were not as strident in their criticisms of practice as some Coroners' or Ombudsman reports.

A systems approach may be the new methodological underpinning of SARs. This could be helpful in thinking about the strengths of current practice and would appear to fall on fertile ground. Braye et al (2015a) suggested that the SCRs reviewed offered a rich picture of the complexity of practice with adults who self-neglect and that they had indeed illustrated the value of detailed guidance, co-ordinated multi-agency work and decision making, and opportunities for debate and information sharing, as noted above. While individual case work in practice may be informed by this the research team also proposed greater attention to the 'organisation round the team', meaning the necessity for supervision and managerial oversight so that practitioners are supported and decisions agreed, then reviewed.

## **Conclusions**

This paper has considered the new system of SARs. We recommend that local SARs are read and discussed; that taking part in them becomes more of a constructive experience and that unwarranted blame is carefully avoided. In focussing on SARs we need to remember the extent of damage that reviews can do and avoid this as far as possible by learning from our colleagues in children's services. While new SARs may be important there is much to learn from the larger SCRs that have prompted changes in policy and practice and how to sustain their recommendations. Thematic analyses are also important in alerting us to new areas of practice, user experience, and insights into team and organisational behaviour.

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